



STATE OF ARKANSAS
Department of Finance
and Administration

EBD
Employee Benefits Division
Post Office Box 15610
Little Rock, AR 72231-5610

Phone: (501) 682-9656 Toll Free: (877) 815-1017 Fax: (501) 682-2366 <http://www.state.ar.us/dfa/ebd>

Arkansas State Retiree Payroll Deduction Authorization



(Agency Insurance Rep use only:)

Date Sent: _____

Agency Name: _____ Agency Number: _____

I, _____, hereby authorize you to deduct from my retirement check such amounts as necessary to pay the premiums for my health insurance plan. I further authorize you to pay such amounts to the insurance company providing such personal insurance or to its authorized representative. **This authorization remains in effect until you receive notice from me in writing that it has been changed or revoked.**

The retirement system that I participate in is: **(Check *only* one of the following)**

- ☐ Public Employees Retirement System (APERS)
☐ Teacher Retirement System (ATRS)
☐ Judicial Retirement System
☐ Arkansas Highway and Transportation Retirement System
☐ Alternative Retirement System (Valic, etc) _____ (Indicate which system)

Please indicate last date of employment _____

My current health insurance carrier is: **(Check one)**

- ☐ Blue Cross Blue Shield PPO ☐ NovaSys HSA PPO*
☐ Health Advantage HMO ☐ NovaSys PPO
☐ Health Advantage POS ☐ NovaSys POS
☐ QualChoice HMO ☐ NovaSys HMO
☐ QualChoice POS ☐ USAbLe Life Only

- ☐ Decline Coverage
☐ Other Insurance
☐ Medicare Only
☐ No Other Coverage
☐ Tricare

Please refer to rate sheet to determine amount(s) to record:

Monthly Amount	Self	Self/Spouse	Self/Children	Family
Health Premium				
Basic Life Volume				
Supplemental Life Volume				
Dependent Life Volume				
Total Premium				

If a member is eligible for Medicare and does not have Part B, the plan will pay as though the member does have Part B and the member will have financial responsibility for claims incurred.

If you or your spouse have Medicare Parts A and B, please provide the following information:

Retiree

Medicare HIC # _____
Medicare Part A Effective _____
Medicare Part B Effective _____

Spouse

Medicare HIC # _____
Medicare Part A Effective _____
Medicare Part B Effective _____

Please sign, date and return within 30 days to the address above, attn: Retirement Section

Signature _____ Date _____ SSN _____

(For Office Use Only)

Effective Date: _____ EBD Initials: _____